



## **Federally Funded Health Care Program Disclosure Form – Individual**

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### **WHAT IS SOUTHWEST MICHIGAN BEHAVIORAL HEALTH**

Southwest Michigan Behavioral Health (SWMBH) is a Prepaid Inpatient Health Plan (PIHP). As a PIHP, SWMBH manages the Medicaid, MiChild, and MI Health Link behavioral health (mental health and substance use disorder) benefits for Region 4. Region 4 is made up of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties.

### **WHAT INFORMATION IS REQUIRED**

The Federal Rules, the Medicaid Provider Manual, and SWMBH's contract with MDHHS require disclosures of information that includes, but is not limited to:

- 1) The identity of all owners and others with a controlling interest (direct or indirect) of 5% or greater;
- 2) Certain business transactions as described in 42 CFR §455.105;
- 3) The identity of managers and others in a position of influence or authority; and
- 4) Criminal conviction information for the provider, owners, and managers.

The information required includes, but is not limited to: name, address, date of birth, Social Security Number (SSN) and tax identification number (TIN).

### **WHY IS THIS INFORMATION REQUIRED**

In order to comply with Federal law (42 CFR 420.200 – 420.206 and 455.100-455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding ownership and control of the entities with which the plan contracts for services paid for by Medicaid and/or Medicare.

This information is required to ensure that SWMBH and its participating Community Mental Health Service Providers (CMHSPs) are not contracting with a provider that has been excluded from participation in State and Federal health programs, or an entity that is owned or controlled by an individual who is excluded, has been convicted of certain criminal offenses, or has had civil monetary penalties imposed against them.

### **WHO IS REQUIRED TO PROVIDE THIS DISCLOSURE**

All providers in SWMBH's managed care network who receive (directly or indirectly) Federally Funded Health Care Program funds.

## **HOW WILL THE INFORMATION BE COLLECTED**

SWMBH contracts with the local CMHSPs in each of the counties in Region 4 to manage and provide mental health services paid for by Medicaid. SWMBH requires the CMHSPs to submit this disclosure for the CMHSP **and** its contracted providers.

SWMBH contracts directly with SUD providers and with MI Health Link providers, and will work directly with these providers to secure completed disclosures.

## **WHAT PROTECTIONS ARE IN PLACE FOR INFORMATION DISCLOSED**

SWMBH implemented a policy specific to Social Security Numbers obtained pursuant to the Ownership and Control Disclosure requirements, as well as a tool to be used in assessing any potential breaches. SWMBH Operating Policy 10.17-Social Security Number Privacy Policy is based on and compliant with the Michigan Social Security Number Privacy Act, Act 454 of 2004. SWMBH Operating Policy Attachment 10.16A – Breach Response Risk Assessment Tool includes a response assessment that is compliant with the Michigan Identify Theft Protection Act, Act 452 of 2004.

In addition to administrative safeguards, there are physical and technical safeguards in place to protect the information gathered by this disclosure. The information is stored on an electronic device that is password protected, and kept in a locked container. The password is changed every 60 days. SWMBH's Chief Compliance & Privacy Officer and a single SWMBH Compliance Specialist hold keys to the locked container and know the password. The locked container is physically stored in a safe that is only accessible by SWMBH's Chief Financial Officer, and all accesses are recorded on an access log.

## **WHAT IF A PROVIDER DOES NOT COMPLETE THIS DISCLOSURE**

The Federal Rules and the Medicaid Provider Manual independently require providers to disclose the information requested in this form. Completion and submission of this form is a condition of participation in SWMBH and each Community Mental Health Service Providers' provider network. ***Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.***

***42 CFR §455.104(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.***

## **HOW OFTEN DOES THIS FORM HAVE TO BE COMPLETED**

The Medicaid Disclosure Form must be submitted at the following intervals:

- 1) Provider enrollment;
- 2) Initial contracting;
- 3) Annual contract renewal;
- 4) Within 35 days of a request for updated information from SWMBH;
- 5) Within 35 days of any changes to the information or change in ownership.

## **WHO DO I CONTACT WITH QUESTIONS?**

Medicaid mental health services providers should contact either the Community Mental Health Service Provider who requested the information from you or the Southwest Michigan Behavioral Health Compliance Department with questions. SUD and MI Health Link providers should contact the Southwest Michigan Behavioral Health Compliance Department with questions.

SWMBH

Alison Strasser

[alison.strasser@swmbh.org](mailto:alison.strasser@swmbh.org)

(269) 488-6981

Barry County Community Mental Health Authority

Brenna Ellison

[brleedy@bccmha.org](mailto:brleedy@bccmha.org)

(269) 948-8041

Pines Behavioral Health (Branch County CMHA)

Megan Daws

[mdaws@pinesbhs.org](mailto:mdaws@pinesbhs.org)

(517) 278-2129

Riverwood Center (Berrien County CMHA)

Sara Schaeffer

[sxd@riverwoodcenter.org](mailto:sxd@riverwoodcenter.org)

(269) 925-0585

Summit Pointe (Calhoun County CMHA)

Rhea Freitag

[rfreitag@summitpointe.org](mailto:rfreitag@summitpointe.org)

(269) 441-5904

Woodlands Behavioral Health Network (Cass County CMHA)

Amy Davidhizar

[AmyD@Woodlandsbhn.org](mailto:AmyD@Woodlandsbhn.org)

269-228-5163

Integrated Services of Kalamazoo (Kalamazoo County CMH)

Ashley Esterline

[aesterline@iskzoo.org](mailto:aesterline@iskzoo.org)

(269) 364-6986

Van Buren Community Mental Health

Liz Evans

[levans@vbcmh.com](mailto:levans@vbcmh.com)

(269) 655-3304

Pivotal (St. Joseph County CMH)

Jarrett Cupp

[jcupp@stjoecmh.org](mailto:jcupp@stjoecmh.org)

(269) 467-1001

# Individual Provider Information

## Instructions

Please fill out the entire section. ***Every field must be complete.*** If fields are left blank, the form will not be processed and will be returned for corrections/completions. If the form is unreadable due to illegible handwriting, the form will not be processed.

<p><b>Please choose appropriate category:</b></p> <p><input type="checkbox"/> <b>Individual Member of a Medical Group</b></p> <p><input type="checkbox"/> <b>Individual Contracted Provider</b></p> <p><input type="checkbox"/> <b>Sole Proprietor</b></p> <p><input type="checkbox"/> <b>HCBS Provider</b></p> <p><input type="checkbox"/> <b>Other:</b></p> <p><b>Group Affiliation?</b>    <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b></p> <p><b>If Affiliated with a Group, do you have a Private Practice as well?</b>    <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b>    <input type="checkbox"/> <b>NA</b></p>	<p style="text-align: center;"><b>Name of Person Completing the Form (First/Middle/Last)</b></p> <hr/> <p>Title</p> <hr/> <p>Phone Number</p> <hr/> <p>Fax</p> <hr/> <p>Email</p>		
<p>Legal Name of Individual (“<b>Individual Provider</b>”): _____ Name of Group (if applicable): _____</p>			
<p>Physical Address</p> <p>STREET                      CITY                      STATE                      ZIP</p>			
<p>+Additional Addresses (list <b>all</b> Practice locations – attach a separate sheet if necessary):</p>			
SSN #:	*Medicaid ID #:	*National Provider ID (NPI) #:	
*If billing under an Entity: Federal Tax Identification #:		*If billing under an Entity: Billing Entity’s NPI #:	
*If billing under an Entity: Billing Entity’s Medicaid ID#:			

*\*These fields cannot be left blank; “N/A” non-applicable and “applied for” are acceptable responses.*  
*\*\*Individual providers please use social security number; field cannot be left blank: “N/A” non-applicable and “applied for” are acceptable responses*

+ Please list “consumers’ homes” or “public community locations” if services are provided in these locations

### Section I: Individual Provider Ownership Information

Are there any individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Individual Provider?  Yes  No

**If yes**, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater. (42 CFR §455.104) **Attach additional sheet as necessary**

Name of Owner (first/middle/last; any alias)	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	** SSN (individual) and/or TIN (entity) <i>List both as applicable</i>

**\*\* SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22**

### Section II: Ownership in Providers & Entities

Does the Owner **identified in Section I** have an Ownership or Controlling Interest in any other provider or entity?  Yes  No  
**If Yes**, list the name and the SSN or TIN of the **other provider or entity** in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3)) **Attach additional sheets as necessary**

Name of Owner from Section I	Name of Other Provider or Entity	Other Provider or Entity's SSN (individual) or TIN (entity)

### Section III: Subcontractor Ownership

Do you have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor?  Yes  No  
**If Yes**, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor?  Yes  No  
**If Yes**, list information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104) **Attach additional sheets as necessary**

<b>Legal Name of Subcontractor</b>			
<b>Name of Subcontractor's Other owner</b>			
<b>Other Owner's complete Address (Street/City/State/ZIP)</b>			
<b>Other Owner's TIN:</b>	<b>Other Owner SSN:</b>	<b>Other Owner's DOB</b> (mm/dd/yyyy)	<b>% Interest in Subcontractor</b>

### Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Sections I, II or III related to each other?  Yes  No  
**If Yes**, list the individuals identified and the relationship to each other (e.g., spouse, domestic partner, sibling, parent, child)  
(42 CFR §455.104(b)(2)) **Attach additional sheets as necessary**

Name of Owner 1:	Name of Owner 2:	Relationship

## Section V: Management & Control

**Managing Employees:** Individual Provider have any Managing Employees?     Yes     No

*If Yes*, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day- to-day operations of your Individual Provider Practice (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104) **Attach additional sheets as necessary.**

Name (first/MI/last)	DOB <small>mm/dd/yyyy</small>	Complete Address (Street/City/State/Zip)	SSN	Title

**Agents:** Do you, as an Individual Provider, have any Agents?     Yes     No

*If yes*, list all Agents that have been delegated the authority to obligate or act on behalf of you, the Individual Provider, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104) **Attach additional sheets as necessary.**

Name (first/MI/last)	DOB <small>(mm/dd/yyyy)</small>	Complete Address (Street/City/State/Zip)	SSN

**Board of Directors:** Do you, as an Individual Provider, have a Board of Directors?     Yes     No

*If yes*, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104) **Attach additional sheets as necessary.**

Name (first/MI/last)	DOB <small>(mm/dd/yyyy)</small>	Complete Address (Street/City/State/Zip)	SSN

**Section VI: Criminal Convictions, Sanction, Exclusions, Debarment, and Terminations\***

1. Have you (the Individual Provider), or any person listed in Section I and/or Section V ever been **convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program?  YES  NO

*If Yes, list those persons and the required information below. (42 CFR §455.106) Attach documentation and additional sheets as necessary.*

<b>Name</b>		
<b>DOB (mm/dd/yyyy)</b>	<b>SSN (individual) or TIN (entity)</b>	<b>State of Conviction</b>
<b>Complete Address (Street/City/State/Zip)</b>		
<b>Matter of the Offense</b>		
<b>State and Date of Conviction(mm/dd/yyyy)</b>	<b>Date of Reinstatement(mm/dd/yyyy)</b>	

2. Have you, or any person listed in Section I and/or Section V ever been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program?  YES  NO

*If Yes, list those persons and the required information below. (42 CFR §455.436) Attach documentation and additional sheets as necessary.*

<b>Name</b>		
<b>DOB (mm/dd/yyyy)</b>	<b>SSN (individual) or TIN (entity)</b>	
<b>Complete Address (Street/City/State/Zip)</b>		
<b>Reason for Sanction, Exclusion or Debarment</b>		
<b>Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)</b>	<b>Date of Reinstatement (mm/dd/yyyy)</b>	<b>List all States where currently excluded:</b>

3. Have you, or any person listed in Section I and/or Section V ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program?  YES  NO

*If Yes, list those persons and the required information below. (42 CFR §455.416) Attach documentation and additional sheets as necessary.*

<b>Name</b>			
<b>DOB (mm/dd/yyyy)</b>	<b>SSN(individual) or TIN (entity)</b>		
<b>Complete Address (Street/City/State/Zip)</b>			
<b>Reason for Termination</b>			
<b>Date of Termination (mm/dd/yyyy)</b>	<b>State that originated Termination</b>	<b>Date of Reinstatement (mm/dd/yyyy)</b>	

*\*At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)*

## Section VII: Business Transaction Information

**Business Transactions - Subcontractors:** Have you, the Individual Provider, had any business transactions with a Subcontractor totaling more than \$25,000 in the previous twelve (12) month period?     **YES**     **NO**

*If Yes*, list the information for Subcontractors with whom the Individual Provider has had business transactions totaling more than \$25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) **Attach additional sheets as necessary.**

Name of <b>Subcontractor</b> :		Subcontractor's SSN (individual) or TIN (entity):	
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:		Subcontractor's Owner's SSN/TIN:	
Subcontractor's Owner's Street Address	City:	State:	ZIP

**Significant Business Transactions – Wholly Owned Suppliers:** Have you, the Individual Provider, had any *Significant Business Transactions* with a Wholly Owned Supplier exceeding the lesser of \$25,000 or 5% of operating expenses in the past five (5) year period?     **YES**     **NO**

*If Yes*, list the information for any Wholly Owned Supplier with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during the past 5-year period (42 CFR §455.105(b)(2)). **Attach additional sheets as necessary. See Glossary for definition.**

Name of <b>Supplier</b> :		Supplier's SSN (individual) or TIN (entity):	
Supplier's Street Address	City:	State:	ZIP

**Significant Business Transactions – Subcontractors:** Have you, the Individual Provider, had any *Significant Business Transactions* with a Subcontractor exceeding the lesser of \$25,000 or 5% of operating expenses in the past five (5) year period?     **YES**     **NO**

*If Yes*, list the information for Subcontractor with whom the Individual Provider has had any Significant Business Transactions exceeding the lesser of \$25,000 or 5% of operating expenses during the past 5-year period (42 CFR §455.105(b)(2)). **Attach additional sheets as necessary. See Glossary for definition.**

Name of <b>Subcontractor</b> :		Subcontractor's SSN (individual) or TIN (entity):	
Subcontractor's Street Address	City:	State:	ZIP
Name of Subcontractor's Owner:		Subcontractor's Owner's SSN/TIN:	
Subcontractor's Owner's Street Address	City:	State:	ZIP

**This information must be provided and/or updated within 35 days of a request. Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received. (42 CFR §455.105)**



**Section VIII: Provider Attestation**

Through signing below, I hereby certify that the information provided herein, is true, accurate, and complete. Additions or changes to the information above will be submitted no later than 35 days after any change to the information or change in ownership. Additionally, I understand that any misleading, inaccurate, or incomplete data may result in denial of participation, denial of claims, and contract termination. Individual Provider must sign the form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Full Name

\_\_\_\_\_  
Date

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Please indicate all Organizations with whom your entity holds a contract:**

Southwest Michigan Behavioral Health

Barry County Community Mental Health Authority:

Riverwood Center (Berrien County):

Pines Behavioral Health (Branch County):

Summit Pointe (Calhoun County):

Woodlands Behavioral Health Network (Cass County):

Kalamazoo County Community Mental Health and Substance Abuse Services:

Community Mental Health and Substance Abuse Services of St. Joseph:

Van Buren Community Mental Health:

## **Instructions for Disclosure of Ownership/Controlling Interest and Management Statement**

*If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.*

### **Section I: Provider Entity Ownership Information:**

Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and P.O. Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

**Providing the SSN and TIN** (as applicable) is required under 42 CFR 455.104; The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, as well as any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a "Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act" on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.

### **Section II: Ownership in Other Providers & Entities:**

Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

### **Section III: Subcontractor Ownership:**

If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

### **Section IV: Familial Relationships of All Owners:**

Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. For a definition of domestic partner, refer to your state's laws. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

### **Section V: Management & Control:**

1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

### **Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment and Terminations:**

List your own criminal convictions, exclusions, sanctions, debarments and terminations, and for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at <https://oig.hhs.gov/exclusions/index.asp>
2. Sanction information is available in the GSA's SAM (System for Award Management) database, [www.sam.gov](http://www.sam.gov)

3. State specific exclusion/sanction databases may be accessed through the State Agency's website, [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders) (Billing and Reimbursement/List of Sanctioned Providers)

**Section VII: Business Transaction Information:**

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than \$25,000 within the last twelve (12) month period ending on the date of the request.
2. List any **Significant Business Transaction** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any **Significant Business Transaction** between your entity and any Subcontractor during the past 5 years.

Remember that a **Significant Business Transaction** is defined as any transaction or series of related transactions that exceeds the lesser of \$25,000 or 5% of a provider's operating expenses during any one fiscal year.

This information must be available within 35 days of a request by the U.S. Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

## GLOSSARY

**Agent:** any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

**CAQH:** Council for Affordable Quality Health. (Credentialing database that some health care providers may use).

**CHIP:** The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MICHild.

**Controlling Interest:** defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

**Determination of ownership or control percentages :**(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

**Direct Ownership Interest:** the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**HCBS Provider:** a provider of Home and Community Based Services for Medicaid beneficiaries.

**Indirect Ownership Interest:** an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

**Managing Employee:** a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency

**Ownership or Control Interest:** an individual or corporation that—

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f) Is a partner in a disclosing entity that is organized as a partnership.

**Other Entity:** any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes:

- (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XV III); (b) Any Medicare intermediary or carrier; and
- (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

**Provider Entity:** an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

**Significant Business Transaction:** any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand (\$25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

**Subcontractor:** (a) an individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or  
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Supplier:** an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

**Wholly Owned Supplier:** a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.